MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

PHYSICIAN RECOMMENDATION FORM

This form must be completed and mailed directly to the **Minnesota Board of Medical Practice** by two US or Canadian licensed physicians with whom applicant has worked during the last five years, has known applicant for more than one year and who can testify to applicant's character, personal reputation, background and professional ability. This form does not have to be filled out by the same physicians you have listed on page 7 of the application. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name_____

Signature_____ Date_____

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Physician)_____

1. How long have you known the applicant?_____
2. What has been the nature of your relationship with the applicant?_____

   _____
3. How would you characterize the moral and professional conduct of the applicant?_____

   _____
4. Would you recommend that the applicant be approved for licensure for the independent, unrestricted practice of medicine?_____
5. Circle the word(s) which best describes this applicant.

A.	Marginal*	Fully Meets Standards	A. Clinical skills
B.	Yes*	No	B. Any indication of chemical dependency?
C.	Yes*	No	C. Any indication of malprescribing?

Completed By:

Print Name_____ Phone_____

Address_____

Signature_____ Date_____

*Please attach letter of explanation.

01/02